SURPRISE MEDICAL BILLING RESPONSE TO CALCULATION REVIEW REQUEST

Michigan Department of Insurance and Financial Services
Office of Research, Rules, and Appeals

<u>DIFS-SurpriseBilling@michigan.gov</u>

Fax: 517-763-0305

Instructions: The carrier must submit this form along with all required documentation listed in section I and return to DIFS by email or fax.

Carrier Name:	DIFS Calculation Review Number:	
Carrier Point of Contact:	Carrier Point of Contact Email:	
Carrier Address:	Carrier Point of Contact Fax:	

I. RATE INFORMATION (REQUIRED)

In the table below, please record the median amount the carrier has negotiated with participating providers for the region and provider specialty for the procedure(s) and service(s) listed in the Notice of Calculation Request letter **or** provide the Department with access to your database. Attach a separate document in the same format as below if additional space is needed.

Procedure/Service Performed CPT/HCPCS code	Carrier Median Negotiated Rate for Region and Provider Specialty	Region Used	Specialty Used

¹ **Please note:** The Carrier's database must: be updated no less frequently than quarterly, be searchable by region, provider specialty, and healthcare service, include all median negotiated rates for all health care services covered by carrier, and be continuously accessible to DIFS.



II. RATIONALE (OPTIONAL)

The carrier may provide a rationale regarding service(s) in question. Attach a separate docume	how the rate of reimbursement was determined for the procedure(s) of ent if additional space is needed.
III. CERTIFICATION AND ACKNOWL	EDGEMENTS
regarding this request, and I certify that the	nowledge that I will respond to the Department's inquiries e information included on this form is correct and complete to the derstand and acknowledge that submitting false or misleading equest.
Authorized Signature:	Date:
Printed Name/Title:	•